NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

PREAMBLE

1.	**Sections Affected**	**Rulemaking Action**
	R9-22-101	Amend
	R9-22-102	Repeal
	R9-22-201	Repeal
	R9-22-201	New Section
	R9-22-202	New Section
	R9-22-217	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: ARS § 36-2903.01 (F)

Implementing statute: ARS § 36-2901(6)(ii); ARS 36-2903.03 (D) and (F)

3. The effective date of the rules:

The effective date will be 60 days from filing with the Secretary of State.

4. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Docket Opening: 12 A.A.R. 1099, April 7, 2006

Notice of Proposed Rulemaking: 13 A.A.R. 1306, April 13, 2007

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

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6. An explanation of the rule, including the agency's reasons for initiating the rule:

The rule has been updated to comply with a recent Consent Decree regarding the coverage of emergency dialysis services for members of the Federal Emergency Services Program (FES). In addition, for easier reference and management of the rules related to the Article, the related definition section has been moved to the beginning of Article 2, and the rules that existed in the beginning of Article 2 were moved to the next available section.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No study was reviewed during this rulemaking and the Agency does not anticipate reviewing any studies.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

It is anticipated that there will be a minimal economic impact, since the emergency dialysis services have been covered for several years as a result of this lawsuit.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

In addition to the change agreed upon from public comment received, the Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

11. A summary of the comments made regarding the rule and the agency response to them:

Commenter Sally Hart from William E. Morris Institute For Justice submitted a comment to the Administration requesting section R9-22-217 (D) be modified to read "Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B)."

The Administration has agreed to modify the rule as suggested.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions
R9-22-102. ~~Scope of Services-related Definitions~~ Repealed

ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-201. ~~General Requirements~~ Scope of Services-related Definitions
R9-22-202. ~~Repealed~~ General Requirements
R9-22-217. Services Included in the Federal Emergency Services Program

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"Accommodation"	R9-22-701
"Act"	R9-22-101
"ADHS"	~~R9-22-102~~ R9-22-101
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary department"	R9-22-701
"Ancillary service"	R9-22-701
“Anticipatory guidance”	R9-22-201
"Annual enrollment choice"	R9-22-117
"APC"	R9-22-701
"Appellant"	R9-22-101
"Applicant"	R9-22-101
"Application"	R9-22-101

“Assessment”	R9-22-1101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-101
“Authorization”	R9-22-201
"Auto-assignment algorithm"	R9-22-117
“AZ-NBCCEDP”	R9-22-2001
"Baby Arizona"	R9-22-1401
"Behavior management services"	R9-22-1201
"Behavioral health adult therapeutic home"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201
"Behavioral health evaluation"	R9-22-1201
"Behavioral health medical practitioner"	R9-22-1201
"Behavioral health professional"	R9-22-1201
"Behavioral health recipient"	~~R9-22-102~~ R9-22-201
"Behavioral health service"	R9-22-1201
"Behavioral health technician"	R9-22-1201
"BHS"	R9-22-1401
"Billed charges"	R9-22-701
"Blind"	R9-22-1501
"Burial plot"	R9-22-1401
“Business agent”	R9-22-701 and R9-22-704
“Calculated inpatient costs”	R9-22-712.07
"Capital costs"	R9-22-701
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-1401
“Case management”	R9-22-1201
"Case record"	R9-22-101

"Case review"	R9-22-101
"Cash assistance"	R9-22-1401
"Categorically-eligible"	R9-22-101
“CCR”	R9-22-712
"Certified psychiatric nurse practitioner"	R9-22-1201
“Charge master”	R9-22-712
“Child”	R9-22-1503 and R9-22-1603
“Children’s Rehabilitative Services” or "CRS"	~~R9-22-102~~ R9-22-201
“Claim”	R9-22-1101
“Claims paid amount”	R9-22-712.07
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	~~R9-22-102~~ R9-22-201
"CMDP"	R9-22-117
"CMS"	R9-22-101
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	A.R.S. § 36-2901
“Copayment”	R9-22-701, R9-22-711 and R9-22-1603
“Cost avoid”	R9-22-1201
"Cost-To-Charge Ratio"	R9-22-701
"Covered charges"	R9-22-701
"Covered services"	~~R9-22-102~~ R9-22-101
"CPT"	R9-22-701
“Creditable coverage”	R9-22-2003 and 42 U.S.C. 300gg(c)
"Critical Access Hospital"	R9-22-701
“CRS”	R9-22-1401
"Cryotherapy"	R9-22-2001
“Customized DME”	R9-22-212

~~"Date of eligibility posting"~~	~~R9-22-701~~
"Day"	R9-22-101 and R9-22-1101
"Date of the Notice of Adverse Action"	R9-22-1441
"DBHS"	~~R9-22-102~~ R9-22-201
"DCSE"	R9-22-1401
"De novo hearing"	42 CFR 431.201
"Dentures" and "Denture services"	~~R9-22-102~~ R9-22-201
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101
"DES"	R9-22-101
"Diagnostic services"	~~R9-22-102~~ R9-22-101
"Director"	R9-22-101
"Disabled"	R9-22-1501
"Discussion"	R9-22-101
"Disenrollment"	R9-22-117
"DME"	~~R9-22-102~~ R9-22-101
"DRI inflation factor"	R9-22-701
"E.P.S.D.T. services"	42 CFR 440.40(b)
"Eligibility posting"	R9-22-701
"Eligible person"	A.R.S. § 36-2901
"Emergency behavioral health condition for the non-FES member"	~~R9-22-102~~ R9-22-201
"Emergency behavioral health services for the non-FES member"	~~R9-22-102~~ R9-22-201
"Emergency medical condition for the non-FES member"	~~R9-22-102~~ R9-22-201
"Emergency medical services for the non-FES member"	~~R9-22-102~~ R9-22-201
"Emergency medical or behavioral health condition for a FES member"	R9-22-217

"Emergency services costs"	A.R.S. § 36-2903.07
"Encounter"	R9-22-701
"Enrollment"	R9-22-117
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Experimental services"	R9-22-101
"Existing outpatient service"	R9-22-701
“Expansion funds”	R9-22-701
"FAA"	R9-22-1401
"Facility"	R9-22-101
"Factor"	R9-22-701 and 42 CFR 447.10
"FBR"	R9-22-101
"Federal financial participation" or "FFP"	42 CFR 400.203
"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"Fee-For-Service" or "FFS"	~~R9-22-102~~ R9-22-101
"FES member"	~~R9-22-102~~ R9-22-101
"FESP"	R9-22-101
"First-party liability"	R9-22-1001
“File”	R9-22-1101
“Fiscal agent”	R9-22-210
“Fiscal intermediary”	R9-22-701
"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"FQHC"	R9-22-101
"Free Standing ~~Children~~ Children’s Hospital"	R9-22-701
“Fund”	R9-22-712.07
~~"Global Insights Prospective Hospital Market Basket"~~	~~R9-22-701~~
“Graduate medical education (GME) program”	R9-22-701
"Grievance"	R9-34-202

"GSA"	R9-22-101
"HCPCS"	R9-22-701
"Health care practitioner"	R9-22-1201
"Hearing aid"	~~R9-22-102~~ R9-22-201
"HCPCS"	R9-22-701
"HIPAA"	R9-22-701
"Home health services"	~~R9-22-102~~ R9-22-201
"Homebound"	R9-22-1401
"Hospital"	R9-22-101
“In-kind income”	R9-22-1420
“Insured entity”	R9-22-720
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR"	42 USC 1396d(d)
"ICU"	R9-22-701
"IHS"	R9-22-117
“IHS enrolled” or “enrolled with IHS”	R9-22-708
"IMD" or "Institution for Mental Diseases"	42 CFR 435.1010 and ~~R9-22-102~~ R9-22-201
"Income"	R9-22-1401 and R9-22-1603
“Indigent”	R9-22-1401
“Individual”	R9-22-211
"Inmate of a public institution"	42 CFR 435.1010
“Inpatient covered charges”	R9-22-712.07
"Interested party"	R9-22-101
“Intern and Resident Information System”	R9-22-701
“LEEP”	R9-22-2001
“Legal representative”	R9-22-101
"Level I trauma center"	R9-22-2101
"License" or "licensure"	R9-22-101

“Licensee”	R9-22-1201
"Liquid assets"	R9-22-1401
"Mailing date"	R9-22-101
"Medical education costs"	R9-22-701
"Medical expense deduction" or "MED"	R9-22-1401
"Medical record"	R9-22-101
"Medical review"	R9-22-701
"Medical services"	A.R.S. § 36-401
"Medical supplies"	~~R9-22-102~~ R9-22-201
"Medical support"	R9-22-1401
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-101
"Medicare HMO"	R9-22-101
"Member"	A.R.S. § 36-2901
"Mental disorder"	A.R.S. § 36-501
“Milliman study”	R9-22-712.07
“Monthly equivalent”	R9-22-1421 and R9-22-1603
“Monthly income”	R9-22-1421 and R9-22-1603
"National Standard code sets"	R9-22-701
"New hospital"	R9-22-701
"NICU"	R9-22-701
“Noncontracted Hospital”	R9-22-718
"Noncontracting provider"	A.R.S. § 36-2901
"Non-FES member"	~~R9-22-102~~ R9-22-201
"Non-IHS Acute Hospital"	R9-22-701
"Nonparent caretaker relative"	R9-22-1401
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
“OBHL”	R9-22-1201

“Observation day”	R9-22-701
"Occupational therapy"	~~R9-22-102~~ R9-22-201
"Offeror"	R9-22-101
"Operating costs"	R9-22-701
“Organized health care delivery system”	R9-22-701
"Outlier"	R9-22-701
"Outpatient hospital service"	R9-22-701
"Ownership change"	R9-22-701
"Ownership interest"	42 CFR 455.101
“Parent”	R9-22-1603
"Partial Care"	R9-22-1201
“Participating institution”	R9-22-701
"Peer group"	R9-22-701
“Peer-reviewed study”	R9-22-2001
“Penalty”	R9-22-1101
"Pharmaceutical service"	~~R9-22-102~~ R9-22-201
"Physical therapy"	~~R9-22-102~~ R9-22-201
"Physician"	~~R9-22-102~~ R9-22-101
“Physician assistant”	R9-22-1201
"Post-stabilization services"	~~R9-22-102~~ R9-22-201 or 42 CFR 422.113
“PPC”	R9-22-701
“PPS bed”	R9-22-701
"Practitioner"	~~R9-22-102~~ R9-22-101
"Pre-enrollment process"	R9-22-1401
“Premium”	R9-22-1603
"Prescription"	~~R9-22-102~~ R9-22-101
"Primary care provider” or “~~(~~PCP~~)~~"	~~R9-22-102~~ R9-22-101
"Primary care provider services"	~~R9-22-102~~ R9-22-201

"Prior authorization"	~~R9-22-102~~ R9-22-101
"Prior period coverage" or "PPC"	~~R9-22-101~~ R9-22-701
"Procedure code"	R9-22-701
"Proposal"	R9-22-101
"Prospective rates"	R9-22-701
"Psychiatrist"	R9-22-1201
"Psychologist"	R9-22-1201
"Psychosocial rehabilitation services"	~~R9-22-102~~ R9-22-201
"Public hospital"	R9-22-701
"Qualified alien"	A.R.S. § 36-2903.03
“Qualified behavioral health service provider”	R9-22-1201
"Quality management"	R9-22-501
"Radiology"	~~R9-22-102~~ R9-22-101
"RBHA" or “Regional Behavioral Health Authority”	~~R9-22-102~~ R9-22-201
“Reason to know”	R9-22-1101
"Rebase"	R9-22-701
"Referral"	R9-22-101
"Rehabilitation services"	~~R9-22-102~~ R9-22-101
"Reinsurance"	R9-22-701
"Remittance advice"	R9-22-701
“Resident”	R9-22-701
"Residual functional deficit"	~~R9-22-102~~ R9-22-201
"Resources"	R9-22-1401
"Respiratory therapy"	~~R9-22-102~~ R9-22-201
“Respite”	R9-22-1201
"Responsible offeror"	R9-22-101
"Responsive offeror"	R9-22-101
"Revenue Code"	R9-22-701

"Review"	R9-22-101
"Review month"	R9-22-101
"RFP"	R9-22-101
“Rural Contractor”	R9-22-718
“Rural Hospital”	R9-22-712.07 and R9-22-718
"Scope of services"	~~R9-22-102~~ R9-22-201
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
"SOBRA"	R9-22-101
"Specialist"	~~R9-22-102~~ R9-22-101
“Specialty facility”	R9-22-701
"Speech therapy"	~~R9-22-102~~ R9-22-201
"Spendthrift restriction"	R9-22-1401
“Sponsor”	R9-22-1401
“Sponsor deemed income”	R9-22-1401
“Sponsoring institution”	R9-22-701
"Spouse"	R9-22-101
"SSA"	42 CFR 1000.10
“SSDI Temporary Medical Coverage”	R9-22-1603
"SSI"	42 CFR 435.4
"SSN"	R9-22-101
"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	~~R9-22-102~~ R9-22-201
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
“Substance abuse”	~~R9-22-102~~ R9-22-201

"SVES"	R9-22-1401
“Therapeutic foster care services”	R9-22-1201
"Third-party"	R9-22-1001
"Third-party liability"	R9-22-1001
"Tier"	R9-22-701
"Tiered per diem"	R9-22-701
"Title IV-D"	R9-22-1401
"Title IV-E"	R9-22-1401
“Total Inpatient payments”	R9-22-712.07
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
“TRBHA” or "Tribal Regional Behavioral Health Authority"	R9-22-1201
“Treatment”	R9-22-2004
"Tribal Facility"	A.R.S. § 36-2981
"Unrecovered trauma center readiness costs"	R9-22-2101
“Urban Contractor”	R9-22-718
“Urban Hospital”	R9-22-718
“USCIS”	R9-22-1401
"Utilization management"	R9-22-501
"WWHP"	R9-22-2001

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Act" means the Social Security Act.

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A),and

Meets license or certification requirements to provide covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"Applicant" means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director. This capped limit can be either a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

"Categorically-eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

"Director" means the Director of the Administration or the Director's designee.

"Discussion" means an oral or written exchange of information or any form of negotiation.

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Enumeration" means the assignment of a nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

“Experimental services” means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:

The weight of the evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or

In the absence of peer-reviewed articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

“Legal representative” means a custodial parent of a child under 18, a guardian, or a conservator.

"License" or "licensure" means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document if there is no legible postmark or postage meter mark.

"Medical record" means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and is kept at the site of the provider.

"Medically necessary" means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417 Subpart L.

"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member's health care.

"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.

"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Radiology" means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member’s eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered services.

"SOBRA" means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member~~;~~,

A marketing organization~~;~~, or

Any other organization or person who agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

R9-22-102. ~~Scope of Services related Definitions~~ **Repealed**

~~In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:~~

~~"ADHS" means the Arizona Department of Health Services.~~

~~"Behavioral health recipient" means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.~~

~~"Children's Rehabilitative Services" or "CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.~~

~~"Clinical supervision" means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.~~

~~"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.~~

~~"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.~~

~~"Dentures" and "Denture services" mean a partial or complete set of artificial teeth and related services that are determined to be medically necessary and the primary treatment of choice, or an essential part of an overall treatment plan, and designed to alleviate a medical condition as determined by the primary care provider in consultation with the dental service provider.~~

~~"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.~~

~~"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.~~

~~"Emergency behavioral health condition for the non-FES member" means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:~~

1. ~~Placing the health of the person, including mental health, in serious jeopardy;~~
2. ~~Serious impairment to bodily functions;~~
3. ~~Serious dysfunction of any bodily organ or part; or~~
4. ~~Serious physical harm to another person.~~

~~"Emergency behavioral health services for the non-FES member" means those behavioral health services provided for the treatment of an emergency behavioral health condition.~~

~~"Emergency medical condition for the non-FES member" means treatment for a medical condition, including labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:~~

1. ~~Placing the member's health in serious jeopardy;~~ ,
2. ~~Serious impairment to bodily functions;~~ ,~~or~~
3. ~~Serious dysfunction of any bodily organ or part.~~

~~"Emergency medical services for the non-FES member" means services provided for the treatment of an emergency medical condition.~~

~~"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount_per_service basis for a member not enrolled with a contractor.~~

~~"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.~~

~~"Hearing aid" means an instrument or device designed for, or represented by the supplier as, aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.~~

~~"Home health services" means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home health aide services, licensed nurse services, and medical supplies, equipment, and appliances.~~

~~“IMD” or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 and licensed by ADHS.~~

~~"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.~~

~~"Non-FES member" means an eligible person who is entitled to full AHCCCS services.~~

~~"Occupational therapy" means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.~~

~~"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.~~

~~"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.~~

~~"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.~~

~~"Post-stabilization services" means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.~~

~~"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.~~

~~"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.~~

~~"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) and (13), and who is responsible for the management of a member's health care.~~

~~"Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.~~

~~"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.~~

~~"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:~~

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.

"Radiology" means professional and technical services rendered to provide medical imaging, radioisotope services, and radiation oncology.

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Specialist" means a Board eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board eligible means a physician who meets all the requirements for certification but has not tested for, or has not been issued certification.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by, or under the supervision of, a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not

~~considered substance abuse for adults who are 21 years of age or older.~~

R9-22-201. ~~General Requirements~~ Scope of Services-related Definitions

~~A. For the purposes of this Article, the following definitions apply:~~

~~1. "Authorization" means written or verbal authorization by:~~

~~a. The Administration for services rendered to a fee-for-service member or~~

~~b. The contractor for services rendered to a prepaid capitated member.~~

~~2. Use of the phrase "attending physician" applies only to the fee-for-service population.~~

~~B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:~~

~~1. Only medically necessary, cost-effective, and federally reimbursable and state reimbursable services are covered services.~~

~~2. Covered services for the federal emergency services program (FESP) are under R9-22-217.~~

~~3. The Administration or a contractor may waive the covered services referral requirements of this Article.~~

~~4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.~~

~~5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.~~

~~6. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider, or upon authorization by the contractor or the contractor's designee.~~

~~7. A member may receive treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.~~

~~8. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.~~

~~9. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.~~

10. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
    a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
    b. Services or items furnished gratuitously, and
    c. Personal care items.
11. Medical or behavioral health services are not covered services if provided to:
    a. An inmate of a public institution;
    b. A person who is in residence at an institution for the treatment of tuberculosis; or
    c. A person age 21 through 64 who is in an IMD, unless provided under Article 12 of this Chapter.

C. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

D. Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.

E. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

F. A service is not a covered service if provided outside the GSA unless one of the following applies:
    1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
    2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
    3. The contractor authorizes placement in a nursing facility located out of the GSA; or
    4. Services are provided during prior period coverage.

G. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

~~H. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.~~

~~I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness.~~

~~J. The restrictions, limitations, and exclusions in this Article do not apply to the following:~~

~~1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27; and~~

~~2. A contractor electing to provide noncovered services.~~

~~a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.~~

~~b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.~~

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Anticipatory guidance" means a person responsible for a child receives information and guidance of what the person should expect of the child's development and how to help the child stay healthy.

"Behavioral health recipient" means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

"Children's Rehabilitative Services" or "CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

"Clinical supervision" means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.

"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.

"Dentures" and "Denture services" mean a partial or complete set of artificial teeth and related services that are determined to be medically necessary and the primary treatment of choice, or an essential part of an overall

treatment plan, and designed to alleviate a medical condition as determined by the primary care provider in consultation with the dental service provider.

"Emergency behavioral health condition for the non-FES member" means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

"Emergency behavioral health services for the non-FES member" means those behavioral health services provided for the treatment of an emergency behavioral health condition.

"Emergency medical condition for the non-FES member" means treatment for a medical condition, including labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

Placing the member's health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

"Emergency medical services for the non-FES member" means services provided for the treatment of an emergency medical condition.

"Hearing aid" means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

"Home health services" means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

“IMD” or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 and licensed by ADHS.

"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.

"Non-FES member" means an eligible person who is entitled to full AHCCCS services.

"Occupational therapy" means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.

"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

"Post-stabilization services" means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

"Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member’s ability to participate in the community and function independently.

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older.

R9-22-202. ~~Repealed~~ General Requirements

A. For the purposes of this Article, the following definitions apply:

1. "Authorization" means written or verbal authorization by:

a. The Administration for services rendered to a fee-for-service member, or

b. The contractor for services rendered to a prepaid capitated member.

2. Use of the phrase “attending physician” applies only to the fee-for-service population.

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:

1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.

2. Covered services for the federal emergency services program (FESP) are under R9-22-217.

3. The Administration or a contractor may waive the covered services referral requirements of this Article.

4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
6. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider or upon authorization by the contractor or the contractor's designee.
7. A member may receive treatment that is considered the standard of care or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.
8. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
9. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
10. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
    a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
    b. Services or items furnished gratuitously, and
    c. Personal care items except as specified under R9-22-212.
11. Medical or behavioral health services are not covered services if provided to:
    a. An inmate of a public institution;
    b. A person who is in residence at an institution for the treatment of tuberculosis; or
    c. A person age 21 through 64 who is in an IMD, unless the service is covered under Article 12 of this Chapter.

C. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

D. Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.

E. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

F. A service is not a covered service if provided outside the GSA unless one of the following applies:

1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
3. The contractor authorizes placement in a nursing facility located out of the GSA; or
4. Services are provided during prior period coverage.

G. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

H. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.

J. The restrictions, limitations, and exclusions in this Article do not apply to the following:

1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27; and
2. A contractor electing to provide noncovered services.
    a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
    b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

R9-22-217. Services Included in the Federal Emergency Services Program

A. Definition. For the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member's health in serious jeopardy,
2. Serious impairment to bodily functions,
3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to another person.

B. Services. Emergency services for a FES member mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for an FES member with End Stage Renal Disease (ESRD) where a treating physician has certified that in his opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy; or
2. Serious impairment of bodily function; or
3. Serious dysfunction of a bodily organ or part.

C. Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered and timely notification as specified in subsection (E) is given. The Administration shall determine whether an emergency condition exists on a case-by-case basis.

D. Prior authorization. A provider is not required to obtain ~~Prior~~ prior authorization ~~is not required~~ for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).

E. Notification. A provider shall notify the Administration no later than 72 hours after a FES member receiving emergency medical or behavioral health services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.